AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY

CITY

MEDICAID PROVIDER NO.

SOCIAL SECURITY NO.

RECIPIENT'S NAME

RECIPIENT'S MEDICAID NO.

PRIMARY ICD-9-CM

SECONDARY ICD-9-CM

DATE OF BIRTH (M M D D Y Y)

SECTION II - ADMISSION

LEVEL OF CARE:
1-Skilled
2-IC
3-IC/MR

PATIENT ADMITTED FROM:
A-Hospital
B-Nursing Facility (NF)
C-State Instit.
D-Own Home
E-Other _____
F-SNF Medicare

ADMISSION DATE (M M D D Y Y)

VA AID & ATTENDANCE INCLUDED:
( )Yes $_____ ( )No

DMA - 6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES (M M D D Y Y) THRU (M M D D Y Y)

PATIENT INCOME

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE:
1-Skilled
2-IC
3-IC/MR

LOC EFFECTIVE DATE: (M M D D Y Y)

VA AID & ATTENDANCE INCLUDED:
( )Yes $_____ ( )No

DMA - 6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES (M M D D Y Y) THRU (M M D D Y Y)

PATIENT INCOME

SECTION IV - TERMINATIONS

REASON:
E - INELIGIBLE
F - DISCHARGED
G - DIED

EFFECTIVE DATE: (M M D D Y Y)

DISCHARGE DESTINATION
A-Home with a Health Plan
B-Hospital
C-Nursing Facility (NF)
D-Other _____
E-Own Home
F-SNF Medicare
L-Limited Stay
Expired

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct. I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient.

Signature of Facility Administrator X _____

DATE (M M D D Y Y)

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker X _____

County Code

DATE (M M D D Y Y)

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